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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2065 CERTIFICATE OF DEATH

02055

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marriottsville Road				d. STREET ADDRESS Marriottsville Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES FREDERICK BOONE				4. DATE OF DEATH Month Day Year Feb. 23, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-21-1878	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME John Adam Boone				14. MOTHER'S MAIDEN NAME Justina Olivia Grice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213-20-4892		17. INFORMANT Address Mrs. Sarah M. Boone, Marriottsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic CV disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH instant chronic							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1954 to 23 Feb , 19 58 , that I last saw the deceased alive on Jan 28 , 19 58 , and that death occurred at 9 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald E. Fisher				DATE SIGNED 2-24-58			
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-26-58		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE FEB 26 '58		24b. REGISTRAR'S SIGNATURE W. L. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

-MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02056

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

2066

1. PLACE OF DEATH a. COUNTY Howard				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland				b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 2 Vineyard Road								d. STREET ADDRESS Rt. 2 Vineyard Road			
3. NAME OF DECEASED (Type or print) ALBERT EDWARD FOUNTAIN								4. DATE OF DEATH Month Feb. Day 17 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 2-10-1904		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright				10b. KIND OF BUSINESS OR INDUSTRY Construction				11. BIRTHPLACE (State or foreign country) Vermont			
12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME LOUIS FOUNTAIN						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-03-4323				17. INFORMANT Anita A. Fountain, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)										INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Donald E. Fisher						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Donald E. Fisher M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						2-18-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 2-24-58		22c. NAME OF CEMETERY OR CREMATORY GODSHEPHERD				22d. LOCATION (City, town, or county) ELICOTT CITY MD	
23. FUNERAL DIRECTOR'S SIGNATURE F. HIGGINBOTHAM, ELICOTT CITY MD				ADDRESS				24a. REC'D BY REGISTRAR 558 21 '58		24b. REGISTRAR'S SIGNATURE Albrecht	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as soon as possible, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

FEB 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2067 CERTIFICATE OF DEATH

02057

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 3803 Cranston Ave.			
3. NAME OF DECEASED (Type or print) First Louise Middle M. Last Graziano				4. DATE OF DEATH Month Febr. Day 1 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/26/92	
9. AGE (In years - last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Santo Scallio				14. MOTHER'S MAIDEN NAME Maria Balsamo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Antonio Graziano - 3803 Cranston Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized (c) 3 yrs.						INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome - psychosis; fecal fistula (ileus bowel resection for volvulus)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 23 , 19 58 , to Febr. 1 , 19 58 , that I last saw the deceased alive on Febr. 1 , 19 58 , and that death occurred at 1:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Febr. 1, 1958							
ACTUAL SIGNATURE Irving J. Taylor M.D.				Taylor Manor Hospital			
PHYSICIAN'S NAME (Type) Irving J. Taylor, M.D.				Taylor Manor Hospital, Ellicott City Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 2/5/58		22c. NAME OF CEMETERY OR CREMATORY Lorraine Maus		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Am. J. Tucker & Sons - Balt.				24. REC'D BY REGISTRAR DATE FEB 4 '58		24b. REGISTRAR'S SIGNATURE W. Beach	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]		RACE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]	

RECEIVED
 FEB 4 1958
 BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **02058**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MELVIN Middle V. Last HAINES		4. DATE OF DEATH Month February Day 24 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-16-1907		9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19 Hours 58 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		11b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Levi T. Haines			
14. MOTHER'S MAIDEN NAME Amanda J. Jenkins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 219-01-9879		17. INFORMANT Address Mrs. Dorothy L. Haines, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Barbiturate Poisoning. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ingested barbiturates while drinking.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2/24 19 58 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Woodbine		(County) Howard		(State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/25/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-27-1958		22c. NAME OF CEMETERY OR CREMATORY Winfield Church of God	
22d. LOCATION (City, town, or county) Carroll Co., Md.		23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		24a. REC'D BY REGISTRAR Winfield, Md.	
24b. REGISTRAR'S SIGNATURE DATE FEB 27 58		24c. REGISTRAR'S SIGNATURE DATE			

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BUREAU V. 1

FEB 97 1958

RECEIVED

CERTIFICATE OF DEATH

02059

Reg. Dist. No.

2069

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION High Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ALFRED PRESTON HAROLD				4. DATE OF DEATH Month Day Year Feb. 27, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-30-1871	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Blacksmith		11. BIRTHPLACE (State or foreign country) Crabottom, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Harold				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Stearl H. Harold, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral vascular collapse 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac failure DUE TO (c) Arteriosclerotic Cardio-vascular disease						INTERVAL BETWEEN ONSET AND DEATH 10 min 20 min 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Jan 31, 1958 , to Feb 27, 1958 , that I last saw the deceased alive on Feb 1, 1958 , and that death occurred at 7:05 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas F. Herbert M.D.				ADDRESS (Street, city or town, state) 46 Church Rd., Ellicott City, Md			
PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.				DATE SIGNED 2/28/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-3-58	22c. NAME OF CEMETERY OR CREMATORY Meadowridge		22d. LOCATION (City, town, or county) (State) Elkridge, Md			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F.C. Higinbotham, Ellicott City, Md.				24a. REC'D BY REGISTRAR DATE MAR 5 '58			
				24b. REGISTRAR'S SIGNATURE W. H. Beach			

TO HOSPITAL: The attending physician; The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be fitted with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CLERGY	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF CLERK	
22. SIGNATURE OF CHIEF OF POLICE		23. SIGNATURE OF DEPUTY CHIEF OF POLICE		24. SIGNATURE OF INSPECTOR	
25. SIGNATURE OF DETECTIVE		26. SIGNATURE OF OFFICER		27. SIGNATURE OF SGT.	
28. SIGNATURE OF CONSTABLE		29. SIGNATURE OF JURY		30. SIGNATURE OF JUDGE	
31. SIGNATURE OF DISTRICT ATTORNEY		32. SIGNATURE OF SHERIFF		33. SIGNATURE OF CLERK	
34. SIGNATURE OF CHIEF OF POLICE		35. SIGNATURE OF DEPUTY CHIEF OF POLICE		36. SIGNATURE OF INSPECTOR	
37. SIGNATURE OF DETECTIVE		38. SIGNATURE OF OFFICER		39. SIGNATURE OF SGT.	
40. SIGNATURE OF CONSTABLE		41. SIGNATURE OF JURY		42. SIGNATURE OF JUDGE	
43. SIGNATURE OF DISTRICT ATTORNEY		44. SIGNATURE OF SHERIFF		45. SIGNATURE OF CLERK	
46. SIGNATURE OF CHIEF OF POLICE		47. SIGNATURE OF DEPUTY CHIEF OF POLICE		48. SIGNATURE OF INSPECTOR	
49. SIGNATURE OF DETECTIVE		50. SIGNATURE OF OFFICER		51. SIGNATURE OF SGT.	
52. SIGNATURE OF CONSTABLE		53. SIGNATURE OF JURY		54. SIGNATURE OF JUDGE	
55. SIGNATURE OF DISTRICT ATTORNEY		56. SIGNATURE OF SHERIFF		57. SIGNATURE OF CLERK	
58. SIGNATURE OF CHIEF OF POLICE		59. SIGNATURE OF DEPUTY CHIEF OF POLICE		60. SIGNATURE OF INSPECTOR	
61. SIGNATURE OF DETECTIVE		62. SIGNATURE OF OFFICER		63. SIGNATURE OF SGT.	
64. SIGNATURE OF CONSTABLE		65. SIGNATURE OF JURY		66. SIGNATURE OF JUDGE	
67. SIGNATURE OF DISTRICT ATTORNEY		68. SIGNATURE OF SHERIFF		69. SIGNATURE OF CLERK	
70. SIGNATURE OF CHIEF OF POLICE		71. SIGNATURE OF DEPUTY CHIEF OF POLICE		72. SIGNATURE OF INSPECTOR	
73. SIGNATURE OF DETECTIVE		74. SIGNATURE OF OFFICER		75. SIGNATURE OF SGT.	
76. SIGNATURE OF CONSTABLE		77. SIGNATURE OF JURY		78. SIGNATURE OF JUDGE	
79. SIGNATURE OF DISTRICT ATTORNEY		80. SIGNATURE OF SHERIFF		81. SIGNATURE OF CLERK	
82. SIGNATURE OF CHIEF OF POLICE		83. SIGNATURE OF DEPUTY CHIEF OF POLICE		84. SIGNATURE OF INSPECTOR	
85. SIGNATURE OF DETECTIVE		86. SIGNATURE OF OFFICER		87. SIGNATURE OF SGT.	
88. SIGNATURE OF CONSTABLE		89. SIGNATURE OF JURY		90. SIGNATURE OF JUDGE	
91. SIGNATURE OF DISTRICT ATTORNEY		92. SIGNATURE OF SHERIFF		93. SIGNATURE OF CLERK	
94. SIGNATURE OF CHIEF OF POLICE		95. SIGNATURE OF DEPUTY CHIEF OF POLICE		96. SIGNATURE OF INSPECTOR	
97. SIGNATURE OF DETECTIVE		98. SIGNATURE OF OFFICER		99. SIGNATURE OF SGT.	
100. SIGNATURE OF CONSTABLE		101. SIGNATURE OF JURY		102. SIGNATURE OF JUDGE	

BUREAU V. S.

MAR 5 1953

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Howard</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cooksville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cooksville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lucy Willis Madison</i>		4. DATE OF DEATH <i>February 19 1958</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>-- 1877 80</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9c. AGE (In years last birthday) <i>80</i> yrs.
10a. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10b. BIRTHPLACE (State or foreign country) <i>MD</i>	
11. FATHER'S NAME <i>Samuel Cook</i>		12. MOTHER'S MAIDEN NAME <i>Harriett -- ?</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		14. SOCIAL SECURITY NO. <i>420.0</i>	
15. INFORMANT <i>Wm Madison - Cooksville, Md.</i>		Address	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest, arteriosclerotic heart disease,</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Congestive failure, arteriosclerosis generalized,</i> DUE TO (c) <i>arteritis -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1957 to 1972-58</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1957</i> 19 <i>Feb</i> to <i>1972</i> 19 <i>Feb</i> , that I last saw the deceased alive on <i>1972</i> 19 <i>Feb</i> , 19 <i>58</i> , and that death occurred at <i>9 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Howard E Hall</i> M.D.		ADDRESS (Street, city or town, state) <i>Bykesville, Md</i> DATE SIGNED <i>1972-58</i>	
PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		<i>BYKESVILLE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-22-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bushy Park</i>	22d. LOCATION (City, town, or county) (State) <i>Cooksville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Willie H. Haight</i> ADDRESS <i>Chykeville, Md</i>		24a. REC'D BY REGISTRAR <i>FEB 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. H. Haight</i>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Baltimore
BIRTH CERTIFICATE OF DEATH

AMIN BOND

U.S. DEPT. OF HEALTH
BUREAU OF VITAL STATISTICS

BUREAU V. 3

FEB 24 1958

RECEIVED

2071 CERTIFICATE OF DEATH

Reg. Dist. No.

02061

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fulton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Simon Rest Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EUGENE W. MERRYMAN		4. DATE OF DEATH FEBRUARY 7th, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27-1880
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Montague Merryman		14. MOTHER'S MAIDEN NAME Mary E. Gatewood	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Louis M. Merryman		Address Fulton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 8 hours 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-30 , 19 58 , to 2-6 , 19 58 , that I last saw the deceased alive on 2-6 , 19 58 , and that death occurred at 6:00 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles S. Whitaker M.D.		ADDRESS (Street, city or town, state) Clarksville, Maryland	
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.		DATE SIGNED 2-7-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-10-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. M. Lee Sons		24a. REC'D BY REGISTRAR 300 N. 4th St. N.E.	24b. REGISTRAR'S SIGNATURE Al. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be attached for use as the burial-transit permit.

02062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cooksville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA ELLEN MITCHELL</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1884</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Randall</u>		14. MOTHER'S MAIDEN NAME <u>Emily Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Mrs. Clinton Williams</u>		Address <u>Elmira, N. Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST, ARTEROSCLEROTIC HEART</u> <u>420.0</u> DUE TO (b) <u>DISEASE, HYPERTENSION, CONGESTIVE</u> DUE TO (c) <u>HEART FAILURE - DIABETES</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>Jan 58</u> TO <u>9 Feb 58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>58</u> , to <u>Feb</u> 19 <u>58</u> , that I last saw the deceased alive on <u>9 Feb</u> 19 <u>58</u> , and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u>		DATE SIGNED <u>9 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		ADDRESS (Street, city or town, state) <u>SYKESVILLE, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cooksville, Howard, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u>		ADDRESS <u>Cooksville, Md.</u>	
24a. RECEIVED BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE			

TO HOSPITAL: [REDACTED] ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
JSM 9/25

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1923		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES		APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
SHOOTING		HOMICIDE		ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		ONE		NONE		NONE	
PHYSICIAN'S SIGNATURE		PHYSICIAN'S NAME		PHYSICIAN'S ADDRESS		PHYSICIAN'S CITY		PHYSICIAN'S STATE		PHYSICIAN'S COUNTRY		PHYSICIAN'S PHONE		PHYSICIAN'S FAX		PHYSICIAN'S TELETYPE	
[Signature]		JAMES EARL RAY		[Address]		MEMPHIS		TENNESSEE		UNITED STATES		[Phone]		[Fax]		[Teletype]	
CORONER'S SIGNATURE		CORONER'S NAME		CORONER'S ADDRESS		CORONER'S CITY		CORONER'S STATE		CORONER'S COUNTRY		CORONER'S PHONE		CORONER'S FAX		CORONER'S TELETYPE	
[Signature]		JAMES EARL RAY		[Address]		MEMPHIS		TENNESSEE		UNITED STATES		[Phone]		[Fax]		[Teletype]	
FAMILY PHYSICIAN'S SIGNATURE		FAMILY PHYSICIAN'S NAME		FAMILY PHYSICIAN'S ADDRESS		FAMILY PHYSICIAN'S CITY		FAMILY PHYSICIAN'S STATE		FAMILY PHYSICIAN'S COUNTRY		FAMILY PHYSICIAN'S PHONE		FAMILY PHYSICIAN'S FAX		FAMILY PHYSICIAN'S TELETYPE	
[Signature]		JAMES EARL RAY		[Address]		MEMPHIS		TENNESSEE		UNITED STATES		[Phone]		[Fax]		[Teletype]	
FAMILY PHYSICIAN'S NAME		FAMILY PHYSICIAN'S ADDRESS		FAMILY PHYSICIAN'S CITY		FAMILY PHYSICIAN'S STATE		FAMILY PHYSICIAN'S COUNTRY		FAMILY PHYSICIAN'S PHONE		FAMILY PHYSICIAN'S FAX		FAMILY PHYSICIAN'S TELETYPE		FAMILY PHYSICIAN'S SIGNATURE	
JAMES EARL RAY		[Address]		MEMPHIS		TENNESSEE		UNITED STATES		[Phone]		[Fax]		[Teletype]		[Signature]	

BUREAU V. E.
FEB 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2073 CERTIFICATE OF DEATH

Reg. Dist. No.

02063

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>50 yrs.</u>				d. STREET ADDRESS <u>Liberty Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HOWARD</u> First <u>WATFIELD</u> Middle <u>SCOTT</u> Last				4. DATE OF DEATH <u>February 17</u> Month <u>17</u> Day <u>1958</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 21, 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Scott</u>				14. MOTHER'S MAIDEN NAME <u>Jenkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Claudine Scott</u> Address <u>Sykesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular Disease</u> 20 yrs DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>2.17.58</u> , 19____, that I last saw the deceased alive on <u>2.15.58</u> , 19____, and that death occurred at <u>11:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. H. Lawson, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Liberty Road at Eldersburg</u> DATE SIGNED <u>2.19.58</u>			
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>				Sykesville P.O., Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>W. Search</u> DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL—ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1958

RECEIVED